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Office of Administrative Law Judges
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Issue Date: 27 March 2007

Case No. 2005-BLA-6077

In the Matter of:
G.C.[1]
Claimant,

v.

APEX ENERGY, INC.,
Employer,
and
KENTUCKY EMPLOYERS' MUTUAL INSURANCE,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

BEFORE: THOMAS F. PHALEN, JR.
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Also, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On July 13, 2005, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 34).[3] The parties requested that a decision be made on the record, and on June 23, 2006, I issued an order cancelling the hearing and granted the motion requesting a decision be made on the record.[4] All parties were afforded the opportunity to present additional evidence, but waived the right to call, examine, and cross examine witnesses, as provided in the Act and the above referenced regulations.

ISSUES

The issues in this case are:

1. Whether the Miner timely filed this claim;

2. Whether the Miner worked at least thirty years in or around coal mines;

3. Whether the Miner has pneumoconiosis as defined by the Act;

4. Whether the Miner's pneumoconiosis arose out of coal mine employment;

5. Whether the Miner is totally disabled due to pneumoconiosis;

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "ALJX" refers to the administrative law judge exhibits.

[4] I now admit this order into evidence as ALJX 2.

6. Whether the miner has one dependent for purpose of augmentation; and

7. Whether the named employer is the responsible operator.[5]

(DX 34).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

G.C. ("Claimant") was born on July 20, 1953 and completed the eleventh grade. (DX 2). Claimant married Sherry Taylor, but they divorced in September of 1976. (DX 2). Claimant then married Henrietta Combs on September 17, 1976 and they remained married at the time this claim was filed. (DX 2). Claimant has no dependent children. (DX 2).

On his application for benefits, Claimant stated that he engaged in coal mine employment for thirty years. (DX 2, 3). Claimant's last coal mine employment was working as a mechanic and welder in 2004. (DX 3). According to the Claimant, he had to cease working when a doctor instructed him he no longer possessed the physical capacity to do his job due to heart and lung problems. (DX 4). Claimant stated he believed the heart and lung problems stem from pneumoconiosis. (DX 2).

Procedural History

Claimant filed a claim for benefits under the Act on May 11, 2004. (DX 2). On April 18, 2005, the District Director, Office of Workers' Compensation, issued a proposed decision and order – denial of benefits. (DX 29). On April 20, 2005, Claimant requested a formal hearing. (DX 30). On July 13, 2005, this matter was transferred to the Office of Administrative Law Judges. (DX 34).

Length of Coal Mine Employment

On his application for benefits, Claimant stated that he engaged in coal mine employment for thirty years. (DX 2). The Director, in a proposed decision and order dated March 8, 2003, determined that Claimant has twenty-eight years of coal mine employment. (DX 29). While Employer contests this issue, it failed to present any argument as to why Claimant has not established thirty years of coal mine employment.

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations.

[5] Employer listed other issues under section 18(B) which are preserved for appeal.

The determination of length of coal mine employment must begin with § 725.101(a)(32)(ii), which directs an adjudication officer to ascertain the beginning and ending dates of coal mine employment by using any credible evidence. There are several permissible sources of credible evidence. First, an administrative law judge may rely solely upon a coal mine employment history form completed by the miner. *See Harkey v. Alabama-By-Products Corp.*, 7 B.L.R. 1-26 (1984). A miner's uncontradicted and credible testimony may also be the exclusive basis for a finding on the length of miner's coal mine employment. *See Bizarri v. Consolidation Coal Co.*, 7 B.L.R. 1-343 (1984); *Coval v. Pike Coal Co.*, 7 B.L.R. 1-272 (1984). If the miner's testimony is unreliable, it is permissible for an administrative law judge to credit Social Security records over the miner's testimony. *See Tackett v. Director, OWCP*, 6 B.L.R. 1-839 (1984).

I do not find a discrepancy between the coal mine employment listed on Claimant's CM-911a employment summary, the Social Security Earnings record, and Claimant's supporting statements and reports. (DX 2-6). However, as Claimant has not testified in this proceeding, I find that the Social Security Earnings as verified by Claimant's summary form, to be the most reliable source to determine Claimant's length of coal mine employment. The regulatory provisions at 20 C.F.R. §725.101(a)(32) (2001) make reference to a table developed by the *Bureau of Labor Statistics*. However, this table does not exist. Rather, the Department uses a table, which is identified as Exhibit 610 of the *Office of Workers' Compensation Programs Coal Mine (BLBA) Procedure Manual*. The Social Security Earnings report reflects the following coal mine employment earnings history:

Year	Earnings	Industry Average for 125 days of CME	Years of Coal Mine Employment
1973	$ 3,000.17	$ 5,898.75	.51
1974	$ 7,039.38	$ 6,080.00	1.00
1975	$ 6,503.80	$ 7,405.00	.88
1976	$ 4,470.64	$ 8,008.75	.56
1977	$ 9,145.44	$ 8,987.50	1.00
1978	$18,684.92	$10,038.75	1.00
1979	$18,950.94	$10,878.75	1.00
1980	$19,626.30	$10,927.50	1.00
1981	$25,381.81	$12,100.00	1.00
1982	$18,558.83	$12,698.75	1.00
1983	$ 9,077.38	$13,720.00	.66
1984	$10,524.00	$14,800.00	.71
1985	$36,033.75	$15,250.00	1.00
1986	$17,771.25	$15,390.00	1.00
1987	$ 4,350.00	$15,750.00	.28
1988	$23,434.50	$15,940.00	1.00
1989	$25,223.67	$16,250.00	1.00
1990	$46,732.08	$16,710.00	1.00
1991	$39,941.00	$17,080.00	1.00
1992	$43,323.50	$17,200.00	1.00
1993	$42,199.26	$17,260.00	1.00

1994	$45,944.65	$17,760.00	1.00
1995	$47,270.75	$18,440.00	1.00
1996	$49,625.93	$18,740.00	1.00
1997	$72,608.42	$19,010.00	1.00
1998	$76,321.81	$19,160.00	1.00
1999	$67,399.32	$19,340.00	1.00
2000	$64,030.08		1.00
2001	$64,750.45		1.00
2002	$69,009.02		1.00
2003	$65,727.30		1.00[6]
Total years of coal mine employment:			28.60

Based on the Social Security Earnings records, I find that Claimant's length of coal mine employment is twenty-eight and six tenths years, or twenty-eight years and seven months.[7]

Claimant's last employment was in the Commonwealth of Kentucky; (DX 3; 6), therefore, the law of the Sixth Circuit is controlling.[8]

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> [T]he three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically

[6] Exhibit 610 of the Office of Workers' Compensation Programs Coal Mine (BLBA) Procedure Manual only lists industry averages through 1999. Even assuming a 3% increase each year, which is far in excess of the annual increase demonstrated over the most recent years, the average earnings would be $21,133.34. As Claimant earnings exceeded this figure in 2000 through 2003, I find that each of these years qualify as a full year of coal mine employment.

[7] I note that Claimant's earnings for 2004 are not included in the Social Security records. He listed that he stopped working on March 15, 2004. (DX 4). However, without any evidence to verify that Claimant was in fact employed, I cannot credit him with his 2004 employment. I note this determination will not affect the outcome of this case.

[8] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

> supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

Employer has presented no evidence that this claim was not filed timely, nor has it even briefed on the issue. Employer has failed to rebut the presumption afforded to the Claimant under § 725.308(c). As such, I find this claim was timely filed.

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Apex Energy Inc. ("Employer") as the putative responsible operator because it was the last operator to employ Claimant for a year. (DX 29). Employer, however, contests this issue. (DX 34). In its brief, Employer fails to set forth any argument as to why it is not the responsible operator. Also, Claimant's Social Security records confirm that Claimant was last employed for more than a year with Employer. (DX 6). As such, I find that Employer is correctly designated as the putative responsible operator.

Dependency

Claimant indicated on his application for benefits that he married Henrietta Combs on September 17, 1976 and that they remained married and live together as of the date this claim was filed. (DX 2). A marriage certificate shows this marriage took place on the date stated by Claimant. (DX 7). Employer made no argument and presented no evidence that Claimant and his wife are not currently married and living together. Therefore, I find Miner has one dependant for purposes of augmentation under Section 725.205.

MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to

submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Director's Exhibits 1-35 are now admitted into evidence for consideration. (DX 1-35).

Claimant selected Dr. Mahmood Alam to provide his Department of Labor sponsored complete pulmonary examination. (DX 8). Dr. Alam conducted the examination on June 25, 2004, while Dr. Patel interpreted the x-ray. (DX 9). I admit Dr. Alam's report and Dr. Patel's x-ray reading under § 725.406(b). I also admit Dr. Burnett's quality-only interpretation of the chest x-ray under § 725.406(c). (DX 10).

Claimant completed a Black Lung Benefits Act Evidence Summary Form which I now admit into evidence as CX 2. (CX 2). Claimant designed Dr. Alexander's x-ray interpretation as CX 1. I now admit that x-ray report into evidence. (CX 1). Claimant also listed Dr. Vuskovich's x-ray interpretation of a July 15, 2004 x-ray under the OWCP evaluation, which Claimant designates as "DX 1." DX 1 is in fact the guide to filing for black lung benefits. Also, Dr. Vuskovich did not provide Claimant with an OWCP evaluation. The x-ray provided by the OWCP was done on June 25, 2004 by Dr. Patel. After reviewing the entirety of the Director's exhibits, I cannot find any x-ray report from Dr. Vuskovich. Also, I note the Director stated this x-ray was not in compliance with § 718.202, as the x-ray film was not on file with the Department of Labor. (DX 29; 22). As there is no indication the x-ray was filed with the Department of Labor, and as it cannot be found in the record, I shall not consider it with this claim.

Claimant also designated the PFT, ABG, and medical report of Dr. Alam conducted on June 25, 2004 as initial evidence.[9] (DX 9). Finally, Claimant designated the treatment records from Appalachian Regional Healthcare under § 725.414(a)(4). (DX 14). Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit Claimant's evidence as designated in its summary form.[10]

[9] On Claimant's summary evidence form, he lists Dr. Alam's OWCP evaluation as being dated September 7, 2004. This is incorrect. Also, the results as listed on the summary evidence form are not the same as listed in Dr. Alam's examination report.

[10] The admission is with the exception of Dr. Vuskovich's x-ray dated July 15, 2004.

Employer completed a Black Lung Benefits Act Evidence Summary Form which I now admit into evidence as EX 3. (EX 3). As initial x-ray evidence, Employer designated Dr. Dahhan's interpretation of the August 5, 2004 x-ray (DX 15) and Dr. Jarboe's reading of a July 27, 2006 x-ray, which I now admit into evidence as EX 1. (EX 1).[11] Employer also designated Dr. Patel's OWCP x-ray taken on June 25, 2004. Employer also designated Dr. Wheeler's reading of the June 25, 2004 x-ray as rebuttal of the Department-sponsored chest x-ray. (DX 27).

Employer designated Dr. Dahhan's August 12, 2004 PFT (DX 15) and Dr. Jarboe's July 27, 2006 PFT results. (EX 1). Employer also designated Dr. Alam's PFT study as part of the OWCP evaluation. (DX 9). Employer also designated the ABG studies Dr. Dahhan conducted on August 5, 2004 (DX 15) and Dr. Alam's OWCP ABGs conducted on June 25, 2004. (DX 9). For medical reports, Employer designated Dr. Jarboe's July 30, 2006 report (EX 1) and Dr. Dahhan's August 12, 2004 report as initial evidence. (DX 15). Employer lists Dr. Fino's report of August 8, 2005 as rebuttal to Dr. Alam's report, which I now admit into evidence as EX 2. (EX 2). Employer lists both Dr. Alam's initial report (DX 9) and his subsequent clarification (DX 11) under the OWCP evaluation. Employer also designated Dr. Dahhan's November 1, 2004 deposition under § 725.414(c). Finally, Employer designates the hospitalization records and treatment records from Mountain Comprehensive Health Corporation. (DX 14).

Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Dr. Dahhan's deposition satisfies the requirements of § 725.414(c). Therefore, I admit Employer's evidence as designated in its summary form.

X-RAYS

Exhibit	Date of X-ray	Date of Reading	Physician / Credentials	Interpretation
DX 9	06/25/2004	06/25/2004	Patel[12] / BCR[13]	Negative
DX 27	06/25/2004	01/05/2005	Wheeler / B-reader,[14] BCR	
DX 15	08/05/2004	08/05/2004	Dahhan / B-reader	Negative
CX 1	11/04/2004	12/16/2004	Alexander / B-reader	1/1pq
EX 1	07/27/2006	07/30/2006	Jarboe / B-reader	Negative

[11] EX 1 consists of Dr. Jarboe's entire July 27, 2006 examination report and all the test results contained therein.
[12] Employer lists Dr. Patel as being B-reader certified. Dr. Patel checked that he was not a B-reader on the x-ray, and his name is not on the list of currently certified B-readers found on the NIOSH B-reader list. Therefore, he will not be accorded with B-reader credentials.
[13] A "BCR" is a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Dr. Patel did check that he was BCR certified, even though Employer and Claimant do not acknowledge this.
[14] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results
DX 14 3/08/2004	- -	50/71'	1.44 1.43*	2.39 2.33*	51 -	60 61*	Yes Yes
DX 9 6/25/2004	Good/ Good	50/71'	2.07 2.24*	3.03 3.17*	81 76*	68 71*	No No
DX 15 8/05/2004	Good/ Good	51/68.5'[15]	2.41 2.44*	3.37 3.34*	79 43*	72 73*	No No
DX 14 9/07/2004	- -	51/71'	2.33 2.25*	3.56 3.44*	79 88*	65 66*	No No
EX 1 7/27/2006	Good/ Good	53/70'[16]	1.65 1.66*	2.30 2.35*	- -	72 71*	Yes Yes

*indicates post bronchodilator values

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying
DX 9	6/25/2004	44.6 41.7*	88.1 92.4*	No
DX 15	8/05/2004	39.4 37.3*	90.7 99.0*	No

*post exercise values

Narrative Reports

Dr. Mahmood Alam examined the Claimant on June 25, 2004. (DX 9). Dr. Alam considered the following: symptomatology (yellow colored sputum, wheezing in hot temperatures and with exertion, dyspnea, a morning cough, intermittent hemoptysis, orthopnea, ankle edema, and paroxysmal nocturnal dyspnea), coal mine employment history (thirty-five years), individual history (pneumonia, attacks of wheezing since 2000, chronic bronchitis since 2003, bronchial asthma since 2003, heart disease/problems in August 2001, other heart attacks in 2003, multiple stints and catheterizations, allergies, diabetes mellitus since 2003 and high blood pressure since the late 1970s), smoking history (1970 until 2001 and again from 2002-March 2004 at a pack a day for a total thirty-three pack years), chest x-ray, PFT, ABG, and an EKG.

[15] Dr. Dahhan listed Claimant's height at 174.0cm, which is equivalent to 68.5 inches. I take judicial notice of this fact.

[16] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 68.5 to 71 inches, I will use the midpoint and find Claimant's height to be 70 inches.

Dr. Alam diagnosed dyspnea, coal workers' pneumoconiosis, and chronic bronchitis, which he attributes to coal dust exposure, tobacco abuse, and Claimant's cardiac etiology. He describes the level of impairment as "moderate." Dr. Alam notes that Claimant has a "history of tobacco abuse" and that he quit recently. He states the "signs and symptoms can be multifactional, but as a reasoned medical opinion, I am confident to say coal dust exposure has contributed in his disability."

Dr. Alam also wrote in a separate letter that he made two diagnoses of coal workers' pneumoconiosis with dyspnea and chronic bronchitis. (DX 11). He states that both these conditions were substantially aggravated by the dust exposure. Finally, in response to a DOL clarification request on September 7, 2004, PFT results (DX 12), Dr. Alam notes that while the pre-bronchodilator results were above disability standards and post-bronchodilator results were below disability standards, this can be explained in very rare instances.[17] (DX 13). He states that the PFT effort itself can induce a very mild bronchoconstriction on a very rare occasion, or that the exercise induced a bronchoconstriction.

Dr. Dahhan examined Claimant on August 5, 2004 and issued a written report. (DX 15). At the time of the examination, Claimant was fifty-one years old, and Dr. Dahhan credited him with thirty-five years of coal mine employment, ending in 2004 as an outside mechanic and welder. He noted that Claimant began smoking at the age of eighteen, but quit after having a heart attack in December of 2003. Dr. Dahhan noted that the examination of the chest showed good air entry to both lungs with no crepitation, rhonci, or wheeze. The ABG showed normal values while the PFT showed a mild obstructive ventilatory defect with no change after the administration of bronchodilators. The chest x-ray showed clear lung fields. Dr. Dahhan concluded within a reasonable degree of medical certainty that based upon all the evidence Claimant does not suffer from coal workers' pneumoconiosis.[18] According to Dr. Dahhan, while the ventilatory defect was mild, there was no evidence of total or permanent pulmonary disability and he retained the physiological capacity to continue his previous coal mining work or a job of comparable physical demand. Dr. Dahhan believed that Claimant's pulmonary impairment was the result of Claimant's lengthy smoking habit with no evidence of pulmonary abnormality secondary to the inhalation of coal dust.

Dr. Dahhan's deposition restated the findings issued in his report. He did however, note that he considered the mild pulmonary impairment to be the result of smoking because Claimant is on multiple bronchodilator therapy – which indicates Claimant's airway obstruction is not fixed, which would be the case if it was due to the inhalation of coal dust.

Dr. Jarboe examined Claimant on July 27, 2006 and issued a report. (EX 1). At the time of the examination, Claimant was fifty-three years old, and Dr. Jarboe considered thirty-five years of coal mine employment, last working as a mechanic and welder on the surface of the coal mines. Dr. Jarboe noted Claimant complained of shortness of breath and could not walk but a few feet without dyspnea. At this time, Claimant used a cane to help him walk, as his legs would

[17] Despite the letter from the claims examiner, the results of the September 7, 2004 PFT are non-qualifying as I have determined Claimant's height to be 70 inches.

[18] He bases this on a normal examination of the chest, normal blood gas studies, obstructive abnormality on the PFT testing and a clear x-ray.

become so weak because of shortness of breath. These problems began with the heart attack which Dr. Jarboe states happened in August of 2001 or 2002.[19] A second heart attack occurred in December of 2003. In 2005, a pace maker-defibrillator was placed in Claimant's chest. A doctor told Claimant he only has ten percent of his heart function, and he is currently on a transplant list.

According to Claimant, his chest wheezes almost constantly – and this worsens with humidity and perfumes.[20] While there is a daily cough (worse in the morning), there is no personal or family history of asthma. Dr. Jarboe considered Claimant's smoking history to begin in his mid-twenties at a pack a day until Claimant quit in August of 2002 when he had his first heart attack. Dr. Jarboe noted a significant weight gain since employment ended (from 190lbs to 275lbs at the time of examination). The physical examination of the chest showed labored respirations with minimal exertion. Claimant exhibits fairly good breath sounds in all lung zones and no rales or wheezes were heard.

In examining the laboratory data, Dr. Jarboe opines that the PFT shows a severe restrictive ventilatory defect with no airflow obstruction present and showing no response to dilators. The diffusing capacity is mildly reduced, but within normal limits when corrected for lung volumes. The ABGs were completely normal, but no exercise was conducted on the advice of Claimant's cardiologist. Dr. Jarboe reviewed the chest x-ray dated July 27, 2006 which was clear for pneumoconiosis.

Dr. Jarboe concludes that there is not sufficient medical evidence to make a diagnosis of coal workers' pneumoconiosis based upon the negative x-ray and other objective evidence. Also, Dr. Jarboe does not feel a diagnosis of legal pneumoconiosis is appropriate. He states that while there is a severe restrictive ventilatory defect, there is a proportionate reduction in both the FVC and the FEV1 which can be seen in coal dust-induced lung disease. However, Dr. Jarboe opines that this impairment is due to heart disease and obesity and not the inhalation of coal dust. Dr. Jarboe notes that Claimant related his dyspnea clearly began around the time he had his first heart attack, and it was only after this that his breathing problems occurred. He states it is a well known fact that severe congestive heart failure (which Claimant has) can cause a restrictive physiology. The congestion in the lungs causes stiffening and a marked reduction in vital capacity. It is also well known that patients with heart failure also have been found to have respiratory muscle weakness and impaired ventilatory drive. Also, Claimant gained around eighty-five pounds in a short time after his coal mine employment ended. This rapid increase in obesity, according to Dr. Jarboe, would play a significant role in Claimant's restrictive disease.

Finally, Dr. Jarboe notes the possibility that Claimant exhibits symptoms of bronchial asthma. Even though no reversible component was demonstrated on the PFT, he gives a history of wheezing which is worsened by environmental irritants and is currently being treated with a combination of medications used for asthma. Finally, Dr. Jarboe notes that congestive heart failure can cause reactive airways disease, which is indistinguishable from "common garden variety asthma."

[19] Dr. Jarboe notes the Claimant cannot remember exactly when the first heart attack occurred.
[20] Because of this condition, Claimant does not wear after-shave.

Dr. Jarboe concludes by stating that Claimant is totally disabled from a respiratory standpoint as demonstrated through the PFT and physical examination. It is his opinion that Claimant no longer possesses the pulmonary capacity to perform his last coal mining job or one of similar physical demand in a dust-free environment. This impairment is primarily caused by heart disease in the form of severe congestive heart failure which has in turn been caused by severe dilated cardiomyopathy, which resulted from a massive heart attack. The secondary cause of the pulmonary impairment is Claimant's obesity. Dr. Jarboe concludes by stating that he found no evidence of a totally and permanently disabling respiratory condition which has been caused by, aggravated by, or substantially contributed to by the inhalation of coal dust or the presence of coal workers' pneumoconiosis. All of his opinions were rendered within the realm of reasonable medical probability.

Dr. Fino conducted a medical evidence review. (EX 2). He examined the following: medical records from the Whitesburg Medical Clinic dated from March 17, 2003 to July 14, 2004; chest x-ray dated May 21, 2003; PFT results dated June 9, 2003; x-ray dated February 22, 2004; PFT and CT scan report dated March 8, 2004; Dr. Alam's June 25, 2004 study and accompanying tests; CT scan report July 9, 2004; Dr. Dahhan's narrative for the August 5, 2004 exam; and a PFT dated September 7, 2004. Dr. Fino opined that the medical evidence showed no sign of clinical pneumoconiosis. While he noted that there is a possibility of legal pneumoconiosis, after citing several studies and the objective testing, he opined that Claimant's pulmonary impairment is solely due to smoking. Dr. Fino stated that Claimant was totally disabled from a respiratory standpoint, but that pneumoconiosis in no way contributed to this pulmonary impairment. It is his opinion that had Claimant never stepped foot into a mine, he would still be disabled from a pulmonary standpoint.

Treatment Records

Both Claimant and Employer submitted medical records from Appalachian Regional Healthcare, located in Whitesburg, Kentucky pursuant to 20 CFR Section 725.414(a)(4).[21] Included are three PFT tests, two of which are outlined above.[22] A number of the reports make reference to Claimant's myocardial infarction that occurred in 2001.

-Report by Dr. Haque dated September 26, 2002 notes claimant has a history of COPD, but his chest was clear to auscultation with bilateral good air entry and no wheezing.

[21] Included in the treatment notes are x-ray reports from several physicians. There is no evidence in the record as to the x-ray reading credentials of these physicians. §718.102(c). Also, these interpretations were all related to the treatment of Miner's condition, and not for the purpose of determining the existence or extent of pneumoconiosis. In addition, there is no record of the film quality for any of these x-rays. § 718.102(b). Finally, the interpreting physicians did not provide an ILO classification for their readings. § 718.102(b). As a result, these x-ray interpretations are not in compliance with the quality standards of § 718.102 and Appendix A to Part 718. Therefore, while I shall admit the reports under Section 725.414(a)(4), I accord the x-ray interpretations contained in the treatment records no weight for the purpose of determining whether Miner suffers from pneumoconiosis under § 718.202(a)(1).

[22] The PFT conducted on June 9, 2003 does not have tracings present, and thus under the regulations, the study is invalid. *See* § 718 Appendix B. This is affirmed by the opinion of Dr. Fino. (EX 2).

-Report by Dr. Garimella dated May 21, 2003 notes a history of COPD and asthma when being treated for mild shortness of breath and fatigue; shows signs of sleep apnea. Examination shows lungs are clear to auscultation.

-Report by Dr. Hannah dated September 8, 2003 which suggests Claimant had a heart attack.

-Report by Dr. Almusaddy dated March 8, 2004 noting Claimant has COPD. Claimant complains of significant dyspnea on exertion, with a productive cough. Dr. Almusaddy diagnosed severe COPD with exacerbation and acute bronchitis based upon physical observation and a PFT which showed severe airflow obstruction (noted above).

-CT Scan report dated March 9, 2004 showing very small tiny pulmonary nodules with no obvious mass or mediastinal lymphadenopathy. CT scan was taken to determine the cause of Claimant's COPD.

-Report by Dr. Almusaddy dated March 15, 2004 noting Severe COPD with exacerbation being treated with an inhaler.

-Report by Dr. Almusaddy dated April 12, 2004 noting chest has bilateral rhonchi and very scattered slight wheezing.

-Report by Dr. Garimella dated March 26, 2004 stating that Claimant is not "able to function with his current employment because of severe cardiomyopathy overall."

-Report by Dr. Garimella dated May 6, 2004 stating that Claimant stopped the intake of cigarettes in the "last few weeks."

-CT scan report dated July 9, 2004 noting there are reactive lymph nodes in the coronal area and AP window region; there is no evidence of a discrete lung mass. CT scan was taken to determine the cause of Claimant's dyspnea.

Smoking History

Claimant reported to Dr. Alam that he smoked approximately from 1970-2001, and again from 2002 until March of 2004 at a pack a day. (DX 9). This equates to thirty-three pack years. Claimant reported to Dr. Dahhan that he smoked a pack a day from the age of eighteen until quitting after his heart attack in "December 2003." (DX 15). This would equate to approximately thirty-two and a half pack years. Claimant reported to Dr. Jarboe that he began smoking in his mid-twenties at a pack a day (which would be the mid 1970's) until he suffered a heart attack in December of 2003. (EX 1). This would equate to approximately twenty-nine pack years. However, in the medical reports, it is noted on May 6, 2004 that Claimant had only recently stopped the intake of cigarettes, which would equate to thirty-four pack years. I find the most recent report from Dr. Garimella to be the most persuasive, but I will take into account the possibility that Claimant smoked on and off during 2001 until 2004 as reported by Dr. Alam. Therefore, I find Claimant smoked thirty-two pack years.

DISCUSSION AND APPLICABLE LAW

Claimant's claim was filed after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

   (iii) Is totally disabled (see § 718.204(c)), and

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This

definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

The record contains five interpretations of four different x-rays. Dr. Patel, who is board certified in radiology, interpreted the June 25, 2004 x-ray as negative for pneumoconiosis. Dr. Wheeler, who is board certified and a B-reader also found this x-ray to be negative. There are no contrary readings. I therefore find this x-ray to be negative.

Dr. Dahhan, who is a B-reader, interpreted the August 5, 2004 x-ray as negative for pneumoconiosis. There are no contrary readings. I therefore find this x-ray to be negative.

Dr. Alexander, who is a B-reader, interpreted the November 4, 2004 x-ray as positive for simple pneumoconiosis. There are no contrary readings. I therefore find this x-ray to be positive for pneumoconiosis.

Dr. Jarboe, who is a B-reader, interpreted the July 27, 2006 x-ray as negative for pneumoconiosis. There are no contrary readings. I therefore find this x-ray to be negative.

I have found three of the x-rays to be negative for pneumoconiosis and only one to be positive. Therefore, I find that the preponderance of the evidence does not support a finding of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). A brief and conclusory medical report which lacks supporting evidence may be discredited. *See Lucostic v. United States Steel Corp.*, 8 B.L.R. 1-46 (1985); *see also*, *Mosely v. Peabody Coal Co,.* 769 F.2d 257 (6th Cir. 1985). Also, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

Dr. Alam examined Claimant and he diagnosed both coal workers' pneumoconiosis and legal pneumoconiosis. (DX 9; 11). In regard to coal workers' pneumoconiosis, Dr. Alam fails to articulate how he arrived at this diagnosis and what objective evidence he considered. He also fails to articulate how he can make a finding of clinical pneumoconiosis in light of a negative x-ray reading. As his conclusions are not clearly tied to objective evidence nor is his reasoning for the diagnosis articulated, I find this area of his opinion to be neither well reasoned nor well documented. Thus, I accord Dr. Alam's diagnosis of clinical pneumoconiosis little weight.

In considering his diagnosis of legal pneumoconiosis, Dr. Alam articulates that upon physical review and based upon individual history that Claimant suffers from dyspnea and chronic bronchitis which can be attributed to both coal dust exposure and smoking history. However, Dr. Alam fails to articulate *how* he concluded that coal dust exposure was partially to blame for Claimant's dyspnea and chronic bronchitis, outside the fact that Claimant had been exposed. As this opinion is not well documented, I only accord Dr. Alam's conclusion regarding legal pneumoconiosis some weight.

Dr. Dahhan examined Claimant and opined that he possessed neither clinical nor legal pneumoconiosis. In concluding that Claimant did not suffer from either form of pneumoconiosis, Dr. Dahhan relied upon a negative x-ray, objective tests, and a physical examination that showed good air entry to both lungs with no crepitation, rhonci, or wheezing. As Dr. Dahhan relies upon objective evidence and clearly articulates his findings in light of that evidence, I find his opinion to be both well reasoned and well documented. Noting his superior credentials, I accord his opinion in regard to both legal and clinical pneumoconiosis probative weight.

Dr. Jarboe examined the Claimant most recently of all the examining physicians. He opined that there is not sufficient evidence to make a diagnosis of either clinical or legal pneumoconiosis. In regard to clinical pneumoconiosis, Dr. Jarboe stated that the objective evidence, including a negative x-ray, did not show any signs of pneumoconiosis. As Dr. Jarboe relies upon objective evidence, I accord his opinion regarding clinical pneumoconiosis probative weight.

Concerning legal pneumoconiosis, Dr. Jarboe notes that the PFT shows a severe restrictive ventilatory defect. This confirms the Claimant's assertions that he suffers from a constant wheeze with a daily cough. Dr. Jarboe also states that he observed Claimant's "dyspnea with minimal exertion." However, while Dr. Jarboe acknowledges the severe ventilatory defect, he opines that this impairment is due to heart disease and obesity, and not the inhalation of coal dust. Dr. Jarboe outlines Claimant's cardiac history and severe rapid weight gain and explains how this condition is responsible for Claimant's current respiratory state. Specifically, Dr. Jarboe notes that Claimant stated his breathing problems began around the time of his first heart attack. As Dr. Jarboe clearly articulates how Claimant's cardiac and obese conditions cause his pulmonary impairment and relies upon objective evidence to make this conclusion, I find his opinion to be well reasoned and well documented. Thus, I accord his opinion regarding legal pneumoconiosis probative weight.

Dr. Fino conducted a medical evidence review and opined that Claimant did not suffer from either clinical or legal pneumoconiosis. Concerning clinical pneumoconiosis, Dr. Fino noted there was no objective evidence supporting a diagnosis of clinical pneumoconiosis. Dr. Fino examined x-rays, as well as CT scan reports which showed no evidence of

pneumoconiosis.[23] As Dr. Fino relied upon objective evidence, given his superior credentials, I accord his opinion regarding clinical pneumoconiosis probative weight.

Dr. Fino also opined that while there was a *possibility* of legal pneumoconiosis simply because Claimant suffered from a pulmonary impairment, the objective evidence clearly showed that the impairment resulted from a lengthy smoking history, and had Claimant never stepped foot into a mine, he would still have the same pulmonary condition. First, Dr. Fino pointed to the variability shown in the various PFT studies conducted in 2004. He opined that such variability is consistent with a smoking-related abnormality as opposed to a coal mine dust-related abnormality. Also, Dr. Fino notes that a CT scan showed evidence of emphysema and an obstructive impairment, which he attributes to smoking and not coal dust. Dr. Fino explains how the pathological evidence correlates emphysema resulting from smoking, not from coal mine employment. The evidence shows a lack of pathological evidence which would point to pneumoconiosis. As the respiratory impairment shows variability over time, Dr. Fino is able to conclude with a reasonable medical certainty that Claimant's breathing impairment is not the result of coal dust exposure, but rather cigarette smoking. Thus, Claimant does not suffer from legal pneumoconiosis. As Dr. Fino clearly articulates his position, relies upon objective evidence, and cites numerous medical studies to support his conclusions, I find his opinion to be very well reasoned and well documented. As such, noting his superior credentials and the detail he put in his report, I accord his opinion regarding legal pneumoconiosis substantive probative weight.

The treatment records make no diagnosis of coal workers' pneumoconiosis. Also, the breathing impairments that are listed (COPD, bronchitis, asthma, etc.) are in no way connected to Claimant's coal mine employment. As such, I accord these records no weight in determining if Claimant suffers from either clinical or legal pneumoconiosis.

Regarding clinical pneumoconiosis, the evidentiary record contains three medical opinions that have received probative weight, and one has received little weight. All the opinions that received probative weight state Claimant does not suffer from clinical pneumoconiosis. Therefore, Claimant has failed to establish the existence of clinical pneumoconiosis through a reasoned medical opinion under § 718.202(a)(4). Concerning legal pneumoconiosis, I have accorded an opinion diagnosing the existence of legal pneumoconiosis little weight, two opinions stating he does not have legal pneumoconiosis probative weight, and one opinion stating he does not have legal pneumoconiosis substantive probative weight. I am most persuaded by the opinions of Drs. Jarboe and Fino. Dr. Jarboe had the advantage of seeing how Claimant's cardiac condition contributed to his pulmonary impairment and Dr. Fino was able to clearly articulate how objective evidence shows the pulmonary impairment is not the result of coal dust exposure. Therefore, I find that Claimant has not proven by a preponderance of the evidence that he suffers from pneumoconiosis under subsection (a)(4).

[23] An administrative law judge may admit a report containing inadmissible evidence, but must determine whether the physician's consideration of the inadmissible evidence affects the weight to be given to that report. *Harris v. Old Ben Coal Co.*, BRB No. 04-0812 BLA (Jan. 27, 2006)(*en banc*)(McGranery and Hall, JJ., concurring and dissenting). Even though Dr. Fino examined x-ray reports from Whitesburg Medical Clinic, I find these reports did not overly influence his opinion, since the other x-ray reports of Drs. Patel and Dahhan along with the CT scan reports confirm his findings.

Claimant has failed to establish the presence of pneumoconiosis under subsection (a)(1)-(4). Therefore, after considering all evidence of pneumoconiosis under §718.202 (a), I find that Claimant has failed to establish the presence of pneumoconiosis.

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203 (2003).

If a miner suffers from pneumoconiosis and was employed ten years or more in the Nation's coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b); *Stark v. Director,* OWCP, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). As I have found that Claimant has established over twenty-eight years of coal mine employment, if I had found that he suffered from pneumoconiosis, he would be entitled to the rebuttable presumption set forth in Section 718.203(b) that his pneumoconiosis arose out of his coal mine employment. However I have found that Claimant does not have pneumoconiosis. Because there is no pneumoconiosis, I find there is no causation.

Total Disability

To be entitled to benefits under the Act, Claimant must also demonstrate that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under Section 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

I have determined that Claimant has not established that he suffers from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Five PFTs have been submitted. Three of the five PFT results are non-qualifying. As it is the Claimant's burden to demonstrate total disability under this section by a preponderance, I therefore find that Claimant has not established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of arterial blood gas studies meet the requirements listed in the tables found at Appendix C to Part 718. Both ABG studies failed to produce values that meet the requirements of the tables found at

Appendix C to Part 718. Therefore, I find that Claimant has failed to establish total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment as an outside mechanic and welder required Claimant to stand up to eight hours a day and lift up to a hundred pounds per day. (DX 4).[24]

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

Dr. Alam's report concludes that Claimant suffers from a moderate pulmonary impairment. Dr. Alam credits Claimant with thirty-five years of coal mine employment, with fifteen years underground, and last working as a mechanic and welder. Dr. Alam fails to articulate what objective evidence he relied upon for diagnosing this level of impairment. An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). Even though Dr. Alam correctly describes Claimant's last coal mine employment, he fails to articulate how he can conclude Claimant's impairment is moderate. Also, he fails to provide an opinion as to whether Claimant can return to his last coal mine employment. As Dr. Alam fails to articulate which objective evidence he relied upon for his finding of a moderate impairment and fails to opine if Claimant can return to his last coal mine employment, I find his

[24] Claimant intimated that his job duties varied greatly, depending on what was needed. The above requirements are the maximum descriptions he provided.

opinion to be neither well reasoned nor well documented. As such, I accord his opinion on total disability little weight.[25]

Dr. Dahhan's report concludes that at the time of the examination, Claimant possesses the pulmonary capacity to return to his former coal mine employment. Dr. Dahhan notes that the objective evidence (PFT) shows only a mild respiratory impairment. Also, Dr. Dahhan states the ABG values were normal, and the physical examination revealed good air entry to both lungs with no crepitation, rhonci, or wheezing. As Dr. Dahhan relies upon objective evidence and clearly articulates his opinion, I find his opinion to be well reasoned and well documented. As such, I accord it probative weight.

Dr. Fino's report concludes Claimant suffers from a mild to moderate variable respiratory impairment and that from a pulmonary standpoint, Claimant is totally disabled. While Dr. Fino conducted an extensive medical evidence review and provided a very detailed report on the *etiology* of the impairment, he fails to articulate how he determined the *level* of the impairment. He simply concludes by stating Claimant is totally disabled, and articulates no rationale for his conclusions. As such, I find his opinion to be well documented, but not well reasoned. Thus, I only accord his findings with some weight.

Dr. Jarboe's report, written nearly two years after Dr. Dahhan's, concludes within the realm of reasonable medical certainty that from a pulmonary standpoint, Claimant is totally and permanently disabled. Dr. Jarboe describes the ventilatory defect as "severe" and notes Claimant could not return to his former coal mine employment or one of similarly arduous labor in a dust-free environment. He bases this upon objective evidence (PFT) and his physical examination. Dr. Jarboe considered thirty-five years of coal mine employment, with Claimant last working as a mechanic and a welder. As Dr. Jarboe relies upon objective evidence in drawing his conclusion and has an accurate picture of Claimant's coal mine employment, I find his opinion to be well reasoned and well documented. As such, I accord it probative weight.

The two most recent reports (Dr. Jarboe's receiving probative weight and Dr. Fino's some weight) found Claimant to be totally disabled from a pulmonary standpoint. The only report to opine that he was not totally disabled was Dr. Dahhan's. On the issue of total disability, I am most persuaded by Dr. Jarboe's report. He had the benefit of conducting the

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[25] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found that Claimant's complete pulmonary evaluation by Dr. Alam is unreasoned for purposes of determining pneumoconiosis as noted above. Also, Dr. Alam's opinion regarding total disability was also unreasoned. However, even if this claim were remanded to the Director to provide a reasoned and documented opinion concerning the existence of pneumoconiosis and total disability, Claimant could not prevail based upon the preponderance standard. Therefore, I find that remand of this case would be futile. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see*, *e.g.*, *Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

most recent pulmonary evaluation and clearly articulated how objective evidence supported his conclusions. Therefore, I find that Claimant has proven by a preponderance of the evidence that he is totally disabled under § 718.204(b)(iv).

Claimant has establish that he is totally disabled under subsection (b)(iv). Therefore, after weighing all evidence concerning total disability under §718.204 (b), I find that Claimant established that he is totally disabled.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether a claimant's total disability was caused by claimant's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith,* 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf*. 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk}*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

Here, I have already determined that Claimant does not suffer from pneumoconiosis. However, both Drs. Fino and Jarboe (the only doctors to diagnose total disability), opined that Claimant's pulmonary condition was not the result of pneumoconiosis. Dr. Jarboe had the benefit of viewing the Claimant most recently. Dr. Jarboe carefully outlined how individuals with chronic congestive heart failure can have a restrictive physiology, and the congestion in the lungs causes stiffening and a marked reduction in vital capacity. Also, he noted that patients

with heart failure also have been found to have respiratory muscle weakness and an impaired ventilatory drive. Dr. Jarboe noted that Claimant was told by his cardiologist that his ejection fraction is only ten percent, which would confirm chronic congestive heart failure. Dr. Jarboe articulates how the decline in Claimant's respiratory impairment is parallel with his heart failure, and also points to an absence of any signs of clinical or legal pneumoconiosis. There is no medical opinion which clearly diagnoses total disability due to pneumoconiosis. As such, I find that Claimant has failed to prove total disability due to pneumoconiosis under § 718.204(c).

Entitlement

G.C. has failed to establish either the existence of pneumoconiosis under §718.202(a) or total disability due to pneumoconiosis under § 718.204(c). Therefore, I find that G.C. is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

ORDER

IT IS ORDERED that the claim of G.C. for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.458 and 725.459. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

A copy of a notice of appeal must also be served on Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.
If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).